

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
HOME-BASED FAMILY CENTERED THERAPY SERVICES

I. Service Description

- A. This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation.
- B. These in-home services should be high quality, family centered, and culturally competent.
- C. Provision of structured, goal-oriented, time-limited therapy in the natural environment of families who need assistance recovering from physical, sexual, emotional abuse, and neglect.
- D. Other issues, including substance abuse relapse prevention, mental illness, personality/behavior disorder, developmental disability, dysfunctional family of origin, and current family dysfunction, may be addressed in the course of treating the abuse/neglect.
- E. Professional staff will provide family and/or individual therapy including one or more of the following areas:
 - 1. Family of origin/intergenerational issues
 - 2. Family organization (internal boundaries, relationships, roles)
 - 3. Stress management
 - 4. Self-esteem
 - 5. Communication skills
 - 6. Conflict resolution
 - 7. Behavior modification
 - 8. Parenting skills/Training
 - 9. Substance abuse relapse prevention
 - a) Substance abuse Counseling/Treatment must be done under the Service Standard “Substance Abuse Treatment” due to the specific legal qualifications of the provider, not under this Homebased Family Centered Therapy service standard.
 - 10. Crisis intervention
 - 10. Strengths based perspective
 - 11. Adoption issues
 - 12. Participation in Child and Family Team meetings
 - 13. Sex abuse
 - 14. Goal setting
 - 15. Family structure (external boundaries, relationships, socio-cultural history)
 - 16. Problem solving

17. Support systems
18. Interpersonal relationships
19. Therapeutic supervised visitation
 - a) Supervised Visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard.
 - b) The Individual and Monthly Visitation Reports must be used to document the supervised visitation portion of the services provided.
 - c) The Monthly Progress Report will be used to document other services provided within this service standard.
- II.** Further instructions on how to facilitate, document, and bill for the visitation is outlined in the Visitation Facilitation Service Standard. Specifically, Section II (Service Delivery Referral Process), Section VI (Billable Units), and Section X (Required Training).
21. Family processes (adaptation, power authority, communications, META rules)
 1. Cognitive behavioral strategies
 2. Brief therapy
 3. Family reunification/preservation
 4. Grief and loss
 5. Domestic violence education
 6. Reactive Attachment Disorder (RAD) support

II. Service Delivery

- A. Services must include 24 hour crisis intake, intervention, and consultation seven days a week and must be provided primarily in the family's home. Limited services may also be provided at a community site.
- B. Services must include ongoing risk assessment and monitoring family/parental progress.
- C. The family will be the focus of service, and services will focus on the strengths of the family and build upon these strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
- D. Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
- E. Services must include development of short and long-term family goals with measurable outcomes that are consistent with the DCS case plan.
- F. Services must be family centered and child focused.
- G. Services may include intensive in-home skill building and must include

- after-care linkage.
- H. Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing. Monthly reports are due by the 10th of each month following the month of service.
 - I. Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
 - J. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.
 - K. The caseload of the Home-Based Family Centered Therapist (HBFCT) will include no more than 12 active families at any one time.
 - L. Services will be provided within the context of the DCS practice model or Probation plan with involvement in Child and Family Team (CFT) meetings if invited.
 - 1. A treatment plan will be developed based on assessment by the provider and agreements reached in the Child and Family Team meetings and/or documented in the authorizing referral.
 - M. Providers are encouraged to use evidence based models such as Child-Parent Psychotherapy, Motivational Interviewing, Cognitive Behavioral Therapy, etc. when providing services.
 - N. DCS may choose to select a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Target Population

- A. Services must be restricted to the following eligibility categories:
 - 1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
 - 2. Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
 - 3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
 - 4. All adopted children and adoptive families.
- B. Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

IV. Crisis Service

- A. “Safely Home Families First” is the Indiana Department of Child Services (DCS) Initiative for 2011.
 - 1. Our goal is to keep as many children “Safely Home” with their caretakers when possible.

2. When removal of a child is necessary, then placement should be with “Families First.”
 3. Placing children with relatives is the next healthiest action to take, regarding meeting a child’s safety needs as well as their emotional needs.
 4. Crisis services may be necessary to prevent the removal of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.
- B. These crisis services are for families who have children at imminent risk of removal. Imminent risk is defined as:
1. Immediate threat of injury or harm to a child when *no interventions* have occurred to protect the child.
 2. Goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.
- C. Criteria for service:
1. The provider must have a crisis intervention telephone number.
 2. The FCM will notify the Provider of a crisis situation and require a 1 hour response on the part of the provider.
 3. One (1) hour response time required. (No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.)
 4. Referrals would be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders). Crisis Intervention services to existing clients in Home Based Services are already included as part of the service standards.
 5. Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.
 6. Crisis payment is for the “incident only”. The “incident” for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
 7. A Crisis Report shall be electronically sent to the FCM within 24 hours. This report should document the start time and end time of the intervention. It shall report the assessment of the situation and recommendations for services, if any.
 8. The referral for this service will be after the incident and will include ongoing services if deemed necessary.

V. Goals and Outcomes Measures

- A. Goal 1: Maintain timely intervention with the family and regular and timely communication with referring worker.

1. Objective: HCS or back-up is available for consultation to the family 24-7 by phone or in person.
 - a) Fidelity Measure 1: 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
 - b) Fidelity Measure 2: 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
 - c) Fidelity Measure 3: 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.
- B. Goal #2: Clients will achieve improved family functioning
 1. Objective: Goal setting and service planning are mutually established with the client and Home Based Therapist within 30 days of the initial face-to-face intake and a written report signed by the Home Based Therapist and client is submitted to the current FCM/Probation Officer.
 - a) Outcome Measure 1: 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period
 - b) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
 - c) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
 - d) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.
- C. Goal #3: DCS/Probation and clients will report satisfaction with services
 1. Objective:
 - a) Outcome Measure 1: DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
 - b) Outcome Measure 2: 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever

results in a larger number) randomly selected from each county served.

VI. Minimum Qualifications

A. MRO

1. Providers must meet either of the following qualifications:

- a) Licensed professional, except for a licensed clinical addictions counselor
- b) Qualified Behavioral Health Professional (QBHP)

B. Direct Worker

1. Direct workers under this standard must meet one of the following minimum qualifications:

- a) Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
- b) Master's degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board
- c) Master's degree in a related human service field and employed by an organization that is nationally accredited by the Joint Commission, Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities. That individual must also:

(1) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:

- a. Human Growth & Development
- b. Social & Cultural Foundations
- c. Group Dynamics, Processes, Counseling and Consultation
- d. Lifestyle and Career Development
- e. Sexuality
- f. Gender and Sexual Orientation
- g. Issues of Ethnicity, Race, Status & Culture
- h. Therapy Techniques

- i. Family Development & Family Therapy
 - j. Clinical/Psychiatric Social Work
 - k. Group Therapy
 - l. Psychotherapy
 - m. Counseling Theory & Practice
- d) Individual must complete the Human Service Related Degree Course Worksheet. For auditing purposes, the worksheet should be completed and placed in the individual's personnel file. Transcripts must be attached to the worksheet.
- e) **Note:** Individuals who hold a Master or Doctorate degree that is applicable toward licensure, must become licensed as indicated in #1 & 2 above.
- f) Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.
- g) In addition to the above:
 - (1) Knowledge of family of origin/intergenerational issues
 - (2) Knowledge of child abuse/neglect
 - (3) Knowledge of child and adult development
 - (4) Knowledge of community resources
 - (5) Ability to work as a team member
- h) Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
 - (1) Belief in the family preservation philosophy
 - (2) Knowledge of motivational interviewing
 - (3) Skillful in the use of Cognitive Behavioral Therapy
 - a. Skillful in the use of evidence-based strategies

C. Supervisor

- 1. Master's or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board

2. Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions
 - a) Services will be delivered in a neutral-valued culturally-competent manner.
3. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision.
 - a) The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body.
 - b) Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies.
 - c) Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.
4. **Shadowing Criteria**
 - a) All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff experience and need.
 - b) Shadowing must be provided in accordance with the policy. The agency must provide clear documentation that shadowing has occurred.
 - c) Individuals providing supervision under this service standard on 11/1/15 will have until 6/30/16 to complete the DCS Supervision Qualification Training. All training requirements must be met within the last 3 years. New staff hired as supervisors on or after 11/1/15 must have DCS Supervision Qualification Training prior to providing supervision.

VII. Billable Units

- A. Medicaid: Services through the Medicaid Rehab Option (MRO) may be Behavioral Health Counseling and Therapy. Medicaid shall be approved appropriate
 1. Medically necessary behavioral health care Skills Training and Development services for the MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.

Billing Code	Description
T1016 HW	Case Management, each 15 minutes
H2014 HW	Skills Training and Development , per 15 minutes
H2014 HW HR	Skills Training and Development, per 15 minutes (family/couple, consumer present)

H2014 HW HS	Skills Training and Development, per 15 minutes (family/couple, without consumer present)
H2014 HW U1	Skills Training and Development , per 15 minutes (group setting)
H2014 HW HR U1	Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present)
H2014 HW HS U1	Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present)

B. DCS Funding

1. Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below.
2. These billable units will also be utilized for services to referred clients who are not MRO eligible and for those providers who are unable to bill Medicaid.

C. Face-To-Face Time with Client

1. Members of the client family are to be defined in consultation with the family and approved by the DCS.
 - a) This may include persons not legally defined as part of the family
2. Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
3. Includes crisis intervention and other goal-directed interventions via telephone with the identified client family
4. Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
5. Includes in-vehicle (or in-transport) time with client provided it is identified as goal- directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).

- a) Travel time is only billable when the client is in the vehicle.
 6. Includes time spent completing any DCS approved standardized tool to assess family functioning.
 7. Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows.
 - a) These activities are built into the cost of the face-to-face rate and shall not be billed separately.
- D. Therapeutic Supervised Visits
1. Time spent facilitating a supervised visit will be billed separately from other services provided in this service standard.
 2. Services provided during facilitated supervised visits must fall within the scope of this service standard.
 3. The Supervised Visitation rate will be the same as the (Service Standard) face-to-face rate, but will include only time spent directly supervising the visit, or in-vehicle (or in-transport) time with client for the purpose of facilitating a Supervised Visit.
 4. Any other billable time as defined in the (Service Standard) face-to-face rate, should be billed under the face-to-face rate, included transport time for other goal directed interventions.
- E. Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:
1. 0 to 7 minutes – Do not bill (0.00 hour)
 2. 8 to 22 minutes – 1 fifteen minute unit (0.25 hour)
 3. 23 to 37 minutes - 2 fifteen minute units (0.50 hour)
 4. 38 to 52 minutes – 3 fifteen minute units (0.75 hour)
 5. 53 to 60 minutes – 4 fifteen minute units (1.00 hour)
 6. **Note on Intermittent supervised visitation:** when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.

F. Interpretation, Translation, and Sign Language Services

1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
2. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.
3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
4. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.
5. Certification of the Interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

G. Court

1. The provider of this service may be requested to testify in court.
2. A Court Appearance is defined as appearing for a court hearing after receiving a written or email request or subpoena from DCS to appear in court, and can be billed per appearance.
3. If the provider appeared in court two different days, they could bill for 2 court appearances.
 - a) Maximum of 1 court appearance per day.
4. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

H. Reports

1. If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid.
2. A referral for 'Reports' must be issued by DCS in order to bill.

I. Crisis Intervention/Response

1. Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis.
2. Most interventions are expected to be in the home. Crisis payment is for the "incident only".
3. The "incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

VIII. Medicaid

- A. For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS.
- B. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS.
 - 1. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client, and therefore may be billable to MRO.
 - 2. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid.
 - 3. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.
- C. The Services not eligible for MRO may be billed to DCS.

IX. When DCS is not paying for Services:

- A. A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family.
- B. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences.
 - 1. **DCS will only pay for reports when DCS is not paying for these services.**
 - 2. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS.
- C. Court testimony will be paid per appearance if requested on a referral form issued by DCS.
 - 1. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

X. Case Record Documentation

- A. Case record documentation for service eligibility must include:
 - 1. A completed, and dated DCS/ Probation referral form authorizing services
 - 2. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
 - 3. Safety issues and Safety Plan Documentation
 - 4. Documentation of Termination/Transition/Discharge Plans

5. Treatment/Service Plan
 - a) Must incorporate DCS Case Plan Goals and Child Safety goals.
 - b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
6. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
 - a) Provider recommendations to modify the service/ treatment plan
 - b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
7. Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
8. When applicable Progress/Case notes may also include:
 - a) Service/Treatment plan goal addressed (if applicable-
 - b) Description of Intervention/Activity used towards treatment plan goal
 - c) Progress related to treatment plan goal including demonstration of learned skills
 - d) Barriers: lack of progress related to goals
 - e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
 - f) Collaboration with other professionals
 - g) Consultations/Supervision staffing
 - h) Crisis interventions/emergencies
 - i) Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
 - j) Communication with client, significant others, other professionals, school, foster parents, etc.
 - k) Summary of Child and Family Team Meetings, case conferences, staffing
9. Supervision Notes must include:
 - a) Date and time of supervision and individuals present
 - b) Summary of Supervision discussion including presenting issues and guidance given.

XI. Service Access

- A. All services must be accessed and pre-approved through a referral form from the referring DCS staff.
- B. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.
- C. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS.

- D. Providers must initiate a re-authorization for services to continue beyond the approved period.

XII. Adherence to DCS Practice Model

- A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.
- B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

XIII. Interpretation, Translation, and Sign Language Services

- A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.
- B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.
- C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.
- D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).
- E. Sign Language should be done in the language familiar to the family.
- F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.
- G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.
- H. No side comments or conversations between the Interpreters and the clients should occur.

XIV. Trauma Informed Care

- A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):
 - 1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"
 3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
 4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization
- B. Trauma Specific Interventions: (modified from the SAMHSA definition)
1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
 2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
 3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XV. Training

- A. Service provider employees are required to complete general training competencies at various levels.
- B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.
- C. Training requirements, documents, and resources are outlined at:
 1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.
 2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
 3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XVI. Cultural and Religious Competence

- A. Provider must respect the culture of the children and families with which it provides services.

- B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.
- C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.
 - 1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
 - 2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
 - 3. The guidebook can be found at: <http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>
- D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.
- E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XVII. Child Safety

- A. Services must be provided in accordance with the Principles of Child Welfare Services.
- B. All services (even individual services) are provided through the lens of child safety.
 - 1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
 - 2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1.
- C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.

